

Case Number:	CM13-0015981		
Date Assigned:	03/12/2014	Date of Injury:	08/01/2011
Decision Date:	04/30/2014	UR Denial Date:	07/24/2013
Priority:	Standard	Application Received:	08/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 63-year-old female with date of injury of 8/01/2011. The most recent primary treating physician's progress report, dated 7/15/2013, lists subjective complaints as pain in the neck, mid and low back and pain in the shoulders, elbows and wrists, bilaterally. The objective findings indicate that an examination of the cervical, thoracic and lumbar spine revealed a decrease in the lordotic curvature. Palpation was notable for tenderness over the paraspinal and bilateral trapezius with slight spasm and muscle guarding. Tenderness to palpation was also noted over the right sacroiliac joint. A stress test for the sacroiliac joint was positive. An examination of the bilateral shoulders revealed tenderness over the supraspinatus tendons, posterior musculature, anterior capsules, subacromial and periscapular regions, and acromioclavicular joints, right side greater than left. An examination of the bilateral elbows revealed tenderness over the medial greater than the lateral epicondyles and over the olecranon processes, bilaterally. An examination of the bilateral wrists revealed tenderness over the flexor and extensor tendons, right side greater than left. The diagnoses include: 1. Cervical/trapezial musculoligamentous strain/sprain; 2. Thoracic musculoligamentous strain/sprain; 3. Lumbar musculoligamentous strain/sprain with right lower extremity radiculitis and right sacroiliac joint sprain; 4. Bilateral shoulder sprain/strain; 5. Bilateral elbow medial and lateral epicondylitis; 6. Bilateral wrist flexor and extensor tendinitis; 7. Aggravation of fibromyalgia, diabetes and high blood pressure; 8. Sleep loss; stress and anxiety; and 9. Gastrointestinal upset. The previous utilization review decision modified the chiropractic request to a limit of six (6) visits. The patient has had physical and occupational therapy and reported minimal benefit. The medical record fails to document any functional improvement from the chiropractic treatment.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

TWELVE (12) CHIROPRACTIC CARE VISITS THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

Decision rationale: The Chronic Pain Guidelines allow for an initial four to six (4-6) visits, after which there should be documented functional improvement prior to authorizing more visits. The medical record failed to document any functional improvement with the previously authorized chiropractic treatment. The request does not meet guideline criteria, and is non-certified.

ORTHOSTIM 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS). Decision based on Non-MTUS Citation http://www.vqorthocare.com/Products/Spec_Sheets/VQO061565REVB_OS4_MDBrochure_5.5x8.5.pdf.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Interferential current stimulation (ICS).

Decision rationale: There is no evidence in the medical record that the patient has had a trial of a TENS unit. TENS units are recommended in the MTUS and Official Disability Guidelines. The Official Disability Guidelines do not recommend devices such as the Orthostim 4 as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The Orthostim 4 is not medically necessary.

